Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: RENAISSANCE HOSPITAL C/O BURTON & HYDE PLLC PO BOX 684749 AUSTIN TX 78768-4749	MFDR Tracking #: M4-07-6822-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TASB RISK MGMT FUND Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: $2,972.29

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was reviewed by FairPay Solutions, an outside firm that reviews charges and compares them to reasonable cost, applying a standard mark-up to the cost of services. The Explanation of Review (item 2 listed above) gives a breakdown of each line item with an explanation of allowable amounts. Payment made was based on this review."

Response Submitted by: TASB Risk Management Fund
12007 Research Blvd.
Austin, TX 78759

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/13/06 – 12/14/06	W10, W4, 97, D01, S01, S04, S06, S31, W1	Inpatient Surgery	$2,972.29	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and former Division rule at 28 TAC §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on June 15, 2007.

1. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.,* in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

2. By letter dated May 26, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of $2,490.98 and an "alternative" "Additional Reimbursement Amount Owed" of $2,547.00. The Division notes that the amount in dispute of $2,972.29 specified in Part IV above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
3. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - W10–No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - W4–No additional reimbursement allowed after review of appeal/reconsideration
   - S04–This item is packaged or bundled into another applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursements for comparable services in your geographical area
   - 97–Payment is included in the allowance for another service/procedure
   - S01–Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area
   - D01–The reimbursement for this line item has been included in the payment recommendation(s) for all covered services which are reported on another line or lines
   - S06–Reimbursemed at acquisition cost + applicable state markup
   - S31–Reimbursment for this service has been limited to a two day inpatient stay per diem
   - W1–Workers Compensation State Fee Schedule adjustment
4. The Division's former rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, 22 TexReg 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the post anesthesia care record finds that anesthesia was first administered to the injured worker at 08:29 hours on 12/13/06. Review the medical record finds that the injured worker was discharged on 12/14/06 at 10:45 AM. The submitted documentation supports that the length of stay exceeded 23 hours; the Division therefore concludes that the services in dispute are inpatient services.
5. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was one calendar day. The type of admission is surgical; therefore, the standard surgical per diem amount of $1,118.00 multiplied by the length of stay of 1 day yields a reimbursement amount of $1,118.00. This amount is recommended.
6. Per former Division rule at 28 TAC §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. Review of the submitted records finds that the health care provider billed revenue code 278 for 1 unit of HCPCS code C1765 for an "IMP BARRIER ADHESION." The provider submitted a purchase order supporting that the cost to the hospital of this implantable was $297.02. 10% of this amount is $29.70, yielding a reimbursement amount of $326.72. This amount is recommended.
7. Additionally, review of the submitted records finds that the health care provider billed for pharmaceuticals exceeding $250.00 per dose. Per former Division rule at 28 TAC §134.401(c)(4)(C) "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%." However, review of the submitted documentation finds no documentation of the cost to the hospital of the disputed pharmaceuticals. Therefore, no additional reimbursement can be recommended.
8. The total recommended reimbursement for the services in this dispute is $1,444.72. This amount less the amount previously paid by the insurance carrier of $2,678.19 leaves an amount due to the requestor of $0.00. No additional reimbursement is recommended for the services in dispute.
9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Margaret Q. Ojeda	08/11/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.